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ABSTRACT

The Wisconsin Framework for Comprehensive School Health Programs is a multistrategy approach to address the entire range of youth risk behaviors and promote the health, well-being and positive development of students and other members of the school-community as an integral part of a school's overall mission. The framework is a collection of empirically supported strategies organized into six components: (1) healthy school environment; (2) curriculum, instruction and assessment; (3) pupil services; (4) student programs; (5) adult programs; and (6) family and community connections. This report is intended to help educators and other experienced education planners learn about the framework and its purposes, and understand why schools may wish to develop a framework that can assist them in defining their capacity to deliver services and instruction to all children around youth risk behaviors, health promotion, and youth development. The report describes the framework itself and its goals and orientations, then details each of the six components of the framework. Members of the state's Student Services/Prevention and Wellness Team are listed, as well as contact people at state cooperative educational service agencies. (Contains 61 references.) (JPB)

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Wisconsin's Framework for Comprehensive School Health Programs

An Integrated Approach

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Wisconsin's Framework for Comprehensive School Health Programs:

An Integrated Approach

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Foreword

"If You're Concerned about Children . . ."

The preceding line is an enticement to the reader to stay with this document. The Department of Public Instruction Student Services/Prevention and Wellness Team recognizes the delicate balance that exists between the health and safety needs of Wisconsin's school-age children and the ability of the state's school districts to meet them with limited resources. As a result, the Framework for Comprehensive School Health Programs (CSHP) was developed and presented with those concerns in mind. We urge you to read on.

At the 1995 Convention of the National Association of School Psychologists, staff from the Centers for Disease Control and Prevention (CDC) shared the following:

> *Young people who suffer physical illness or injury, mental health problems, hunger, pregnancy, alcohol and drug use, or fear of violence are less likely to learn irrespective of our efforts to improve educational methods, standards, or organization.*

Hardly a profound revelation, we agree. But, what is succinctly expressed in this statement is that young people cannot and will not learn when they are hurting and we must therefore assume no "tinkering" with the educational institution under the guise of "reform" will be successful without addressing the physical, mental, social and emotional needs of students.

The Wisconsin Framework for CSHP described on the following pages provides an organizer, or a sense-maker, for those efforts to address the health and safety needs of students that may be fragmented and disjointed. While the organization of education and services for health and safety may look different in every school, our framework is meant to inspire and guide. Hopefully, you will find it helpful. The ultimate goal, what is figuratively and literally, at the heart of our Framework, is the development of *healthy, successful, resilient learners.*

Some might say we can't afford to have schools address the myriad of problems students bring to the school-house door each day. We believe we can't afford not to. Bonnie Benard, recognized as a leader in the field of resiliency, says it well in a letter dated March 16, 1995:

> *This point which is consistently and pervasively ignored in educational policy and reform, is our ticket as preventionists and providers of support services to "sit at the table" in discussions of educational reform, restructuring, closing the achievement gap, etc. We should be playing the critical role in these discussions; we must speak our truth, especially to the Back-to-Basics pundits that continually force a dichotomy between the affective and cognitive, between meeting developmental needs and academic learning, etc. We need to inspire others - and each other- by putting this bold vision out there!*

We see this Framework as being a fluid and dynamic entity. We will continue to examine it, evaluate it, and refine it in order to maintain and enhance its utility and relevance to schools and communities, our team, and this department. We invite you to join us on this journey.

"If you're concerned about children . . ."

The Student Services/Prevention and Wellness Team

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Acknowledgements

We would like to thank everyone who has helped us to shape this Framework into what it is today. Groups which have been particularly helpful include our collaborative partners within the Department of Public Instruction, at the Department of Health and Family Services, and the Cooperative Educational Services Agencies (CESAs), as well as the 20 school-community teams we began to work with in August of 1994. Many other people have given us valuable feedback at presentations we have made on the Framework.

The Midwest Regional Center for Drug-Free Schools and Communities (MRC) prepared a review of literature related to the Framework for the Department of Public Instruction in March, 1995. This review was used extensively in the development of this document. Many of the references from that review are included as citations here. The original researchers are cited whenever possible in this document.

Nic Dibble acted as the lead author and editor for this publication. Mary Jo Venne and Angela Wilson-Richards provided technical support. Victoria Horn designed the cover.

Introduction

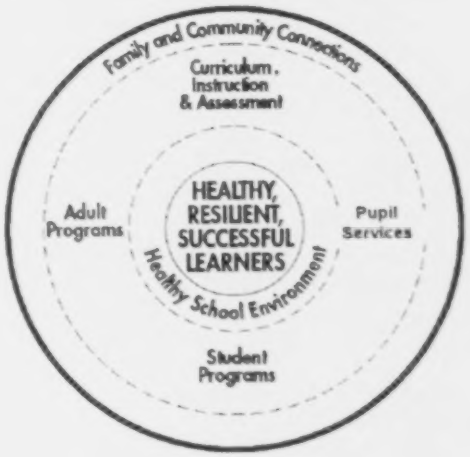
What's in a Name?

For some individuals, the name "Comprehensive School Health Programs" (CSHP) means the work of the health educator and school nurse to meet the physical health needs of children. This limited view couldn't be farther away from the truth in our promotion of a framework for comprehensive school health programs in Wisconsin. A Comprehensive School Health Program is not discipline specific nor discipline driven, but represents a collection of school efforts to address various youth risk behaviors and to promote the health and well being of children. It supports and promotes a variety of disciplines, programs, services and individuals working together to build a system around our children to ensure they have the greatest potential possible to overcome life's challenges and become healthy and productive citizens.

Throughout the past two decades schools have increasingly been asked to address a variety of youth risk behaviors that plague our society. Federal and state funding has been available for such issues as alcohol and other drug abuse, violence, sexual behaviors that result in pregnancy, STDs/HIV/AIDS, suicide and others. Many schools have developed strong single issue prevention programs. In addition, many traditional school disciplines such as school guidance, health education, family and consumer education and others have a strong health and safety focus embedded within their delivery. CSHP provides a vehicle in which schools can build on these existing efforts and integrate them into a well organized whole.

Figure 1

Wisconsin's Framework for Comprehensive School Health Programs



The Wisconsin Framework for Comprehensive School Health Programs describes a multistrategy approach which seeks to address the entire range of youth risk behaviors[1] and promote the health, well-being and positive development of students and other members of the school-community as an integral part of a school's overall mission. It is a collection of empirically supported strategies organized into six components which are most effective and efficient when implemented in a connected and integrated manner **[see Figure 1]**. All of these components are included in the Framework to provide the comprehensive capacity to reach and meet the needs of all students in all situations throughout their school careers. These six components are a *Healthy School Environment; Curriculum, Instruction, and Assessment; Pupil Services; Student Programs; Adult Programs; and Family and Community Connections.* At the center of the Framework is its primary goal of *healthy, resilient, successful learners.* Each of the components are defined and discussed within this document. The purposes of the Wisconsin Framework for CSHP are 1) to communicate the critical and essential role schools play in the positive development of *healthy, resilient, successful learners*; 2) to serve as a "sense-maker" or

[1] Youth risk behaviors include but are not limited to the following: violence and aggression; sexual behaviors that result in pregnancy, STDs/HIV/AIDS; alcohol, tobacco and other drug abuse; suicide; intentional and unintentional injuries; unhealthy dietary patterns; and sedentary lifestyles.

"organizer" for schools concerning how to create an integrated, comprehensive service delivery system; 3) to assist schools in defining their role and capacity in addressing the health and safety needs of children within the school setting; and 4) to act as a functional system for the Department of Public Instruction for integrating the services, programs and funds related to prevention and the health and positive development of children.

We have identified ten guiding principles for the Framework. They help to further communicate the purposes of the Framework as well as our fundamental beliefs related to it.

Guiding Principles

1. **All young people, regardless of risk status, are capable of becoming healthy, resilient, successful learners.** All children have worth and deserve the necessary opportunities to become contributing members of society.
2. **Youth are not the problem but must be part of the solution.** Students must be engaged in the instructional process and the planning of services which affect their lives. With the necessary education and support, they are capable of being effective service providers for their peers.
3. **The four orientations of prevention, health, resiliency, and youth development all have value and are compatible.** When considered together, these orientations form a foundation for a more effective system of programs, instruction, and services. Professionals heavily invested in different orientations can work together toward a common goal of *healthy, resilient, successful learners.*
4. **Health promotion, youth development, and prevention of risk behaviors should be an integral part of a school's approach to education.** No amount of education reform will result in better educational performance unless the issues of violence, sexual activity, alcohol and other drug abuse, hunger, and other concerns are addressed in proactive manners as part of that reform.
5. **Families are the primary prevention and youth development agents for their children.** Families include parents, grandparents, aunts and uncles, and other primary care givers. They are the primary teachers of their children. We can support them but can never take their place.
6. **Learning from research and practice is crucial.** We must select and implement strategies based upon proven effectiveness. This is true more than ever in times of declining resources.
7. **Collaboration and teams are important to a comprehensive continuum of services, because meeting the needs of children requires the combined capacity of all segments of society.** No single organization is able to provide all services to all children and families. We must develop partnerships with families, agencies, employers, and other community-based organizations and individuals in order to fully meet the needs of young people. School-based teams can help to ensure students and families are connected to all important services.
8. **Integration of funding, programs, and services contributes to effective collaboration and efficient delivery of education to children and families.** Operation of programs and services in parallel manners with their associated funding can result in duplication, lack of continuity, less effective outcomes, and consumer confusion.
9. **Services and instruction should be culturally competent and help ensure educational equity**[2]. Services and instruction must be available to all students and families and provided in a manner which respects their different backgrounds and life situations.
10. **Assessments of system's strengths and needs should drive programs that are continuously evaluated and accountable to stakeholders.** We must continuously strive to improve services and instruction. Program accountability must be based upon actual results, rather than just the accomplishment of process objectives, in order for programs to survive and thrive.

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[2]Educational equity is defined as equitable access, treatment, opportunity, benefit, and success for each and every Wisconsin learner regardless of gender, race, religion, national origin, ancestory, creed, sexual orientation, pregnancy, marital or parental status and physical, mental, emotional or learning disability consistent with Wisconsin Statute 118.13.

This Framework has been designed and refined by the Student Services/Prevention and Wellness Team at the Department of Public Instruction (DPI) with ongoing input from educators and others across the state. It builds on and enhances the strengths of Wisconsin schools' current multistrategy programs.

Central to the concept of the Framework is its ability to encompass existing models and orientations. It does not dictate any of them as being primary but gives a school-community the freedom to do so if it wishes. Because of this, the Framework can serve as a vehicle through which people with different models and orientations can come together at a common table and work toward a mutual goal of *healthy, resilient, and successful learners*. The four primary orientations of prevention, health, resiliency, and youth development are defined and discussed separately in this document. We believe these orientations complement each other rather than being mutually exclusive.

A self-assessment instrument based upon the Framework and designed to help schools integrate their services and instruction around youth risk behaviors, health promotion and youth development is available through the SSPW team. Another publication describes the process of local CSHP development from the experience of many school-communities in Wisconsin.

The purpose of this document is to help educators and other experienced education planners 1) learn about the Framework and its purposes, and 2) understand why schools may wish to develop a framework that can assist them in defining their capacity to deliver services and instruction to all children around youth risk behaviors, health promotion, and youth development.

The Framework

Schools in Wisconsin have used multistrategy models which deal with one or more youth risk behaviors for several years. These programs have shown steady progress in their development over time (Wisconsin Department of Public Instruction, 1991a, 1992, 1993a, 1993b, 1995). The relatedness of the different youth risk behaviors has been established (Benson, 1991; Dryfoos, 1990). The American Psychological Association (1994) notes: *One-time single solution approaches will not succeed. Comprehensive, interdisciplinary services for children and families are required.* There are a number of other sources which discuss and promote the effectiveness of multistrategy approaches in addressing youth risk behaviors (Kolbe, 1992; American School Health Association, 1992; Cortese and Middleton, 1994; USDHHS PHS, 1993; Lavin, Shapiro, & Weill, 1992; and Wisconsin Department of Public Instruction, 1991b).

Integration of funding, programs, and services contributes to effective collaboration and efficient delivery of education to children and families.
Guiding Principle #8

The Framework has been designed to build on and enhance the strengths of Wisconsin schools' current programs. To begin with, it is a reflection of the three most common multistrategy, school-based models in our state: the Wisconsin Model for Comprehensive AODA Programs, the Wisconsin Developmental Guidance Model, and the national model for Comprehensive School Health Programs. The Wisconsin Model for Comprehensive AODA Programs includes the components of a school-community advisory council, curriculum, student programs, and adult programs (Wisconsin DPI, 1991b). The Wisconsin Developmental Guidance Model focuses on three major areas of student development: Learning, Personal/Social Health, and Career/Vocational. These are the types of functional life competencies each person must attain in order to learn, achieve academic success, and prepare for a satisfying and productive career (Wilson, 1994). The national model for Comprehensive School Health Programs includes the components of school environment; health education; health services; physical education; counseling, guidance, and mental health; school food service and nutrition; work site health promotion; and integration of school and community activity (Kolbe, 1992; American School Health Association, 1992). Hofford and Cate (1993) describe the purpose of comprehensive school health programs as being *to protect and promote the health and well-being of students, teachers, administrators, and support staff* (pp. 4-5). The *Guidelines for Comprehensive School Health Programs* published by the American School Health Association (1992) states the intent of the program is to *enable children and youth to enhance their health, develop to their fullest potential and establish productive and satisfying relationships in their present and future lives* (p. 1). The World Bank (1993) identifies school health programs as one of the most cost-effective strategies to improve the health of populations across the globe.

The features of all of these models are included in the Wisconsin Framework for CSHP. We have specifically called it a framework and not a prescribed model, because we believe strongly that schools and communities must follow a process to design their own system of strategies which address youth risk behaviors and promote health and youth development. The Framework serves as an example

Health promotion, youth development, and prevention of risk behaviors should be an integral part of a school's approach to education.
Guiding Principle #4

which schools may choose to adopt or adapt. Ted Sizer's advice about school reform is fitting: *In order to be good, a school has to reflect its own community. And therefore, we offer no model* (O'Neill, 1995, p.4).

The Goal of the Framework

The ultimate goal of the Framework is to develop and support *healthy, resilient, successful learners* by helping schools organize their programs, services, and instruction into an integrated system. We have defined these learners as those who:

1. avoid unhealthy risk behaviors and factors;
2. actively make informed decisions to maintain and enhance their health and well-being;

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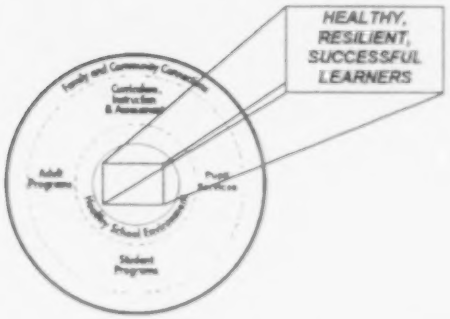
3. are engaged in an ongoing process to reach their full potential to meet their needs and to build skills that allow them to contribute in their daily lives to society, their families and their own personal well-being; and
4. are able to adapt successfully despite exposure to adversity.



The Council of Chief State School Officers (1992) offers a similar definition of a successful learner.

If all children and youth are to develop the skills and competencies they need to assume ... adult responsibilities, our national investment in the development of children and youth must transcend the school's traditional focus on cognitive development. We must redefine what we mean when we speak of 'student success' and broaden our understanding of education to encompass children's continuing intellectual, physical, emotional and social development and well-being ... We must define the outcomes we seek for all children in positive terms and align actions to achieve those positive objectives ... To make the most of our investment ... educators must work collectively with all those who touch the lives of children (pp. 1, 11, 14).

All young people, regardless of risk status, are capable of becoming healthy, resilient, successful learners.
Guiding Principle #1

The Joint Committee on National Health Standards (1995) offers seven National Health Education Standards which also are closely related to our definition of a *healthy, resilient, successful learner*.

1. Students will comprehend concepts related to health promotion and disease.
2. Students will demonstrate the ability to access valid health information and health-promoting products and services.
3. Students will demonstrate the ability to practice health-enhancing behaviors and reduce health risks.
4. Students will analyze the influence of culture, media, technology, and other factors on health.
5. Students will demonstrate the ability to use interpersonal communication skills to enhance health.
6. Students will demonstrate the ability to use goal-setting and decision-making skills to enhance health.
7. Students will demonstrate the ability to advocate for personal, family, and community health.

It is important for communities to determine what they want for their youth. The key question to ask is, "What healthy traits and skills do we want our youth to develop and demonstrate as they grow into adulthood?"

Orientations of the Framework

Historically in many school districts, student services and instruction to address youth risk behaviors have been organized around categorical funding and professional disciplines and may have operated in isolation of each other. Specific youth risk behaviors and/or school professions are sometimes associated with a particular model (e.g., Wisconsin Developmental Guidance Model, Wisconsin Model for a Comprehensive AODA Program, national model for Comprehensive School Health Program) or orientation (i.e., prevention, health, resiliency, or youth development). Some people adopt a particular model or orientation as a result of their professional education (e.g., health education, counseling). Other people's theoretical orientations may evolve as a result of continuing education throughout their professional careers. These models and orientations serve as theoretical "filters" through which we organize our thinking about the programs, services, and instruction we provide. In some cases, individuals and programs within school systems may have a great deal invested

The four orientations of prevention, health, resiliency, and youth development all have value and are compatible.
Guiding Principle #3

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in their respective models or orientations. The result can be parallel programs with great potential for duplication of and gaps in services and instruction as well as barriers to integrated programming. Declining funding can exacerbate competition between staff and programs as they perceive the need to compete for fewer and fewer dollars.

Central to the concept of the Framework is its ability to encompass existing models and orientations mentioned above. The Framework does not dictate any of them as being primary but gives a school-community the freedom to do so if it wishes. Because of this, the Framework can serve as a vehicle through which people with different models and orientations can come together at a common table and work toward a mutual goal of *healthy, resilient, successful learners*. The four orientations of prevention, health, resiliency, and youth development are defined and discussed spearately (see Figures 2-5].

Figure 2

Prevention Orientation

Prevention was defined in September, 1994 by the Wisconsin Task Force on Improving Services to Children and Families.

Prevention strategies are designed to be implemented before the onset of problems and may be targeted to the larger community or to specific populations. Prevention is the process which provides people with the resources necessary to confront stressful life conditions and avoid behaviors which could result in negative physical, psychological or social outcomes by:

- *promoting awareness, knowledge, competency and skills;*
- *promoting self esteem and self reliance;*
- *promoting increased coping ability;*
- *promoting support systems in families, schools, work places and community environments;*
- *promoting conditions for healthy lifestyles and resistance to physical and psychological illness and disease; and*
- *promoting environmental conditions for a healthy community.*

This definition is one of primary prevention (i.e., prevention of difficulties prior to their appearance or adverse impact) and is consistent with the Framework. However, the scope of the Framework also includes what are referred to as secondary and tertiary prevention. Secondary prevention involves specific interventions with young people who are demonstrating difficulties in one or more areas (e.g., alcohol or other drug use, pregnancy, etc.). Tertiary prevention involves support for reentry of a young person returning to school from a treatment setting.

Prevention has traditionally focused on the reduction of specific risk behaviors, such as sexual activity or drinking and driving, rather than the needs and assets of the whole individual. This youth risk concentration has included provision of knowledge specific to each risk area. The definition of primary-secondary-tertiary prevention provides a continuum to ensure students in all circumstances are provided with necessary instruction and opportunities.

We believe the orientations of prevention, health, resiliency, and youth development all have value and are compatible with each other (Gibbs and Bennet, 1990) rather than being mutually exclusive as some proponents of one or more of these would suggest. The focus on risk factors and reduction commonly associated with prevention and health has been criticized by some as involving a destructive "labeling" of young people which is incompatible with emphasizing personal assets and promoting positive youth development. Clearly, there is a danger here (Benard, 1993a, p. 4). However, recognizing that some young people are in life situations which put them in a higher risk situation (e.g., engaging in unprotected sex, being a member of a gang) and may require unique interventions,

"From the classroom to the cafeteria to the playground to the school office -- every adult who interacts with youth everyday plays a significant role in the health and safety of children."
John T. Benson, State Superintendent

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does not prevent service providers from building on personal and environmental assets as part of those interventions. Indeed, refusing to recognize the high risk status of some youth can prevent service providers from designing the most appropriate intervention. "Labeling" young people becomes destructive when they are viewed as "damaged goods" by virtue of their high risk status and are tracked into programs which underestimate their potential. The focus of the Framework is on the development of *healthy, resilient, successful learners*. That goal is not compatible with seeing any young people as being any more or less capable than others of reaching that goal.

The complementary nature of the orientations of prevention, health, resiliency, and youth development can be shown in a number of ways. The basic outcomes of these four orientations are evident within the definition given earlier for *healthy, resilient, successful learners*. All of them encompass strategies to make environments more supportive and healthier. The skills and competencies developed through prevention also contribute to positive youth development, build personal assets, and help youth to make healthy decisions. Health promotion and disease prevention can be viewed as part of the prevention continuum (i.e., primary-secondary-tertiary prevention). Because of this and health's holistic view of the individual, health serves as a bridge or connector between prevention and the other two orientations of resiliency and youth development. Resilient individuals can be viewed as those who have internalized the prevention continuum in order to become their own primary prevention agents. Resilient communities foster youth development. Finally, people need to be resilient in different ways throughout their development from childhood to adolescence and into adulthood.

Figure 3

Health Orientation

The Report of the 1990 Joint Committee on Health Education Terminology provided the following definitions for health literacy, health promotion and disease prevention, and healthy lifestyle.

Health literacy is the capacity of an individual to obtain, interpret, and understand basic health information and services and the competence to use such information and services in ways which are health enhancing.

Health promotion and disease prevention is the aggregate of all purposeful activities designed to improve personal and public health through a combination of strategies including the competent implementation of behavioral change strategies, health education, health protection measures, risk factor detection, health enhancement and health maintenance.

A healthy lifestyle is a set of health-enhancing behaviors, shaped by internally consistent values, attitudes, beliefs and external social and cultural forces.

Although not explicitly stated in these definitions, we consider health to include all of the dimensions of physical, social, mental, and emotional health. In addition, we expand the definition of health literacy to include the capacity of families to be health literate as well as individuals (i.e., students). Children have the capacity to be health literate at their own developmental levels but need the support of their families and school-communities to become fully health literate. The American School Health Association goals are to promote health and wellness; prevent specific diseases, disorders and injury; prevent high risk social behaviors; intervene to assist children and youth who are in need or at risk; help support those who are already exhibiting special health care needs; and promote positive health and safety behaviors (1992, p. 1).

Health has historically taken a holistic view of the individual while at the same time seeking to address specific health problems and issues (e.g., communicable diseases, use of tobacco).

Figure 4

Resiliency Orientation

Over the last few years, Bonnie Benard has offered a number of definitions to help explain resiliency. In 1991, she identified the personal attributes of social competence, problem-solving skills, autonomy, and a sense of purpose and future. She also identified the protective assets within an environment of caring and support, high expectations, and opportunities for participation (Northwest Regional Educational Laboratory, 1991, pp. 3-17). One definition she has used was developed in 1991 by Mary Hoopman and Martha Colby Rivkin at the Minneapolis Public Schools. Resiliency was understood *as the capacity to spring back, rebound, successfully adapt in the face of adversity, and develop social competence despite exposure to severe stress* (Northwest Regional Laboratory, 1992, p. 1.14). Benard characterized a resilient community as *a motivated community where people solve problems together* (1993, p. 1). More recently, she (personal communication, March 16, 1995) described resiliency as *each child's innate potential for healthy development and learning*.

An article from the Wisconsin Clearinghouse examined the literature through 1988 and identified protective factors related to young people's beliefs, relationships and family characteristics (1990, p. 26). The authors argue that protective factors were at least as important as risk factors in youth drug-related behaviors.

The idea of resiliency began with longitudinal research which showed that over a 30 year period, the presence of high-risk conditions did not predict negative outcomes when nurturing, supportive, protective factors were present in the school, the greater community, or family (Werner & Smith, 1992). Resiliency has put the spotlight on building protective assets in young people and environments rather than focusing on risk status and "fixing" young people.

Figure 5

Youth Development Orientation

Karen Pittman has defined youth development as: *the ongoing process in which all youth are engaged in attempting 1) to meet their basic personal and social needs to be safe, feel cared for, be valued, be useful and be spiritually grounded, and 2) to build competencies that allow them to function and contribute in their daily lives* (Pittman, O'Brien, & Kimball, 1993, p. 7).

The authors identify psychosocial outcomes that give youth a sense of safety and protection, self-worth and self-concept, autonomy, closeness and affiliation, belonging, spirituality and self-awareness. In addition, competency outcomes describe the behaviors, skills, and knowledge needed by youth to function fully. These needs include physical and emotional safety, building relationships with caring and connected adults, acquiring information and knowledge, and engaging in meaningful and purposeful activities. Finally, there must be clear and consistent expectations that youth will set goals, devise necessary strategies, make efforts, and follow social rules (Pittman, O'Brien, & Kimball, 1993). Pittman and Cahill (1992) are careful to say *youth development goes on whether or not adults offer support* (p. 24). They list five basic competency areas that define the range of behaviors and skills needed for adult success: 1) health/physical competence, 2) personal/social competence, 3) cognitive/creative competence, 4) vocational competence, and 5) citizenship (ethics and participation) (p. 20).

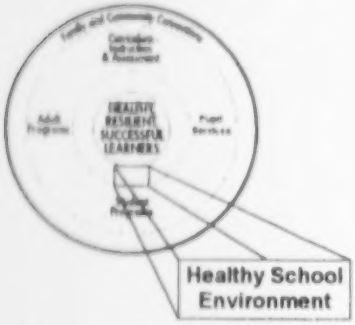
An individual's unique process of development takes place over time in mental, social, physical, and emotional areas and involves changing capacities and skills to deal with life. This development is both active and passive. It is dependent upon both ongoing and appropriate opportunities to continue to develop and inherent abilities (e.g., intelligence, physical stature).

Like health, youth development takes a holistic view of people. Unlike prevention, it states what we want young people to become rather than what we want them to avoid. Youth development closely parallels the Wisconsin Learner Goals (Pittmann & Cahill, 1992, p. 19) and what the literature teaches us about effective schooling (Saphier & King, 1985).

The Components of the Framework

The Wisconsin Framework for CSHP is made up of six components working together in concert toward the goal of developing *healthy, resilient, successful learners*. These components are a *Healthy School Environment; Curriculum, Instruction, and Assessment; Pupil Services; Student Programs; Adult Programs;* and *Family and Community Connections*. All of these components and their associated effective strategies were included in the Framework in order to provide the comprehensive capacity to reach and meet the needs of all students in all situations throughout their school careers. In addition, the Framework seeks to connect and integrate the different components in order to maximize both effectiveness and efficiency. Activities in one component should support and build on activities within itself and other components.

What follows is an explanation of each of these six components. These explanations will include definitions and examples, citations to support the component and its strategies, unique contributions of the component to the Framework, and connections to other parts of the Framework. State discretionary AODA program grants are designed around the Framework. These grants are available through DPI to assist school districts in the development and integration of the six Framework components.



Healthy School Environment

We define a *Healthy School Environment* as the culture and climate that exist within a school that support the physical, mental, emotional, and social well-being and safety of all its members. Nutrition, transportation, and custodian services are necessary features of a *Healthy School Environment*. This component gives importance to healthy students and staff. It makes connections between healthy children and improved learning.

The *Healthy School Environment* is not a program but a result of all the experiences that impact on the school. The environment is built through the everyday business of school life. A *Healthy School Environment* goes beyond the classroom and includes the playground, hallways, school bus, and any school interaction or activity. It is shaped and created by all those who interact in this environment including students, teachers, administrators, coaches, pupil services staff, parents, custodians, secretaries, teacher aides, bus drivers, cooks and visitors. The *Healthy School Environment* supports and is uniquely interrelated with an effective learning environment.

Pittman, O'Brien, and Kimball (1993) identify one of the basic needs of youth to be physical and emotional safety. Benard (personal communication, March 1, 1995) strongly recommends that developing a shared vision is the first step in creating a successful system which includes a positive school environment. Saphier and King (1985) posit that good seeds grow in strong culture. *An academically effective school is distinguished by its culture: a structure, process and climate of values and norms that channel staff and students in the direction of successful teaching and learning* (p. 67). The authors suggest that 12 cultural norms affect school improvement. They are collegiality; experimentation; high expectations; trust and confidence; tangible support; tapping the knowledge base; recognition; caring, celebration, and humor; involvement in decision-making; protection of what is important; traditions; and open communication. These norms would apply to students and staff. Louis and Smith (1992) found that teacher engagement is essential in an effective school culture. The needed engagement is with the school as a social unit, with students as unique individuals, with academic achievement, and with a subject discipline. Participation in school breakfast programs is associated with improved academic functioning, attention to school tasks, and reduced tardiness and absenteeism (Meyers, 1988 & 1989; Neeland, 1993; Center on Hunger, Poverty and Nutrition Policy, 1995; and Pertz & Putnam, 1982).

A report prepared by the Midwest Regional Center for Drug-Free Schools and Communities (1995) for the Wisconsin DPI explores four important aspects

Assessments of systems' strengths and needs should drive programs that are continuously evaluated and accountable to stakeholders.
Guiding Principle #10

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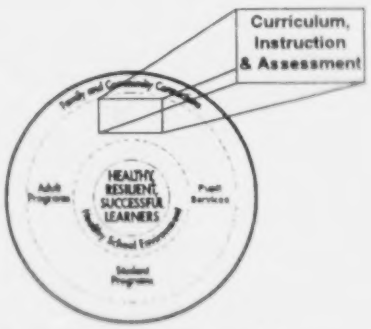
of environmental enhancement: systemic change, leadership, teams, and school culture (p. 12). The report goes on to state, *Without question, literature from many disciplines support youth involvement. Youth engagement will happen only when adults begin with a vision of positive youth development and make necessary systemic changes. These changes will create environments in which young people can tap their own innate potential for full intellectual, social, and personal development. The new environment will include programs, activities, and opportunities which grow out of this vision* (p. 43).

There are many elements to a *Healthy School Environment*. A school vision and mission statement recognize and articulate an important role for schools in supporting the health of children. Policies and practices are clearly designed to carry out the vision and mission of the school. Opportunities are provided which include students in shaping decisions which affect their school lives, such as student councils, student courts and development of classroom rules. Providing an adequate, designated area for children to be dropped off and picked up at school ensures physical safety. Students are able to exercise healthy decision-making by offering them a choice of menu items in the food service program and allowing them to decide the size of the food portions they will eat. Students and adults alike are treated in mutually respectful manners. Visitor signs are welcoming rather than authoritarian. Parents are encouraged to come to school without the need to call first. Adults model healthy lifestyles of regular exercise, good nutrition and hygiene, and nonuse of tobacco products. Buildings and grounds are maintained to ensure safety. Bus drivers extend the physical and emotional safety of the school to their vehicles.

Services and instruction should be culturally competent and help ensure educational equity.
Guiding Principle #9

A *Healthy School Environment* can have a large impact on the effectiveness of all other components of the Framework and is integral to the education of children. It serves as a filter through which the other components flow in developing *healthy, resilient, successful learners*. This environment is the fertile ground in which programs and activities can grow, be truly interconnected, and mutually reinforce a common purpose. It is the context within which all the component pieces interact. Nutrition education is more likely to result in students eating the foods they learn about in class if these same foods are available for lunch in the cafeteria. Conversely, instruction about tobacco will be much less likely to keep students from smoking if students see tobacco products in teachers' pockets and purses, or if there is a smoking area just off the school campus. Parent involvement is enhanced when families feel truly welcome in the school. Collegiality and teamwork can be improved when building principals support staff, families, and other community partners and include them in meaningful decision-making. Interventions with students such as small group counseling are more likely to be successful when the entire school environment is supportive.

Probably the best indicator of a *Healthy School Environment* is that people, all of the students and adults alike, simply want to be there.



Curriculum, Instruction & Assessment

The *Curriculum, Instruction, and Assessment* component involves planning, implementing, and evaluating a sequential and developmentally appropriate PreK-12 curriculum that deals with all important health and safety issues. Although primarily included in the subject areas of health, physical education, science, family and consumer education, social studies, and driver education and traffic safety, the curriculum transcends all disciplines to be delivered in an integrated, multidisciplinary approach.

Connecting the various health and safety topics addressed within the curriculum requires the exploration of the underpinnings or beliefs inherent in all health and safety topical areas. These underpinnings or beliefs can provide the overriding outcomes that all health and safety instruction strives for.

A Guide to Curriculum Planning in Alcohol and Other Drug Abuse Programs (Kleusch, 1992) lists

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four fundamental principles which are human development issues. These principles are:

1. To varying degrees, people have the ability to influence and to be influenced.
2. Personal choices have consequences for oneself and for others.
3. Society has a responsibility to set reasonable boundaries that are in the best interest of all members.
4. Each person has the responsibility to promote the health and safety of oneself and others.

Acceptance of these beliefs is basic not only for alcohol and other drug abuse (AODA) prevention but for prevention of other related problems such as human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS), teen pregnancy, school violence, sexual assault, suicide, and eating disorders. Instruction and support services which are designed to help students examine these four fundamental principles in depth lead to *healthy, resilient, successful, learners.*

The specific content of a curriculum dealing with health and safety issues that children and families face is shaped by the school's mission and vision. In other words, if the school believes it shares responsibility for preventing HIV infection, that acceptance demands that AIDS/HIV instruction becomes part of the curriculum. As a result, health issues become part of the daily learning experience for students. Curriculum development coordinates and integrates classroom instruction specific to the well-being of students and families.

A second feature of this component is instructional and assessment methods which help students develop a love of learning and commitment to life-long health and safety. Curriculum goals and classroom methods should develop skills and competencies, critical thinking, and self-reflective capacities that go beyond acquisition of knowledge. Such methods help students understand deeply the challenge of adopting health-promoting behaviors and assess their ability and willingness to do so. For example, rather than merely role playing refusal skills in the classroom, students would be expected to practice and assess their ability to use that skill in daily life in a variety of situations. Service learning opportunities in the community can be another example. In other words, the instructional and assessment methods are performance-based and connect classroom content to students' lives outside the classroom.

Teaching is the most basic function schools provide. Inclusion of health and safety issues in the curriculum is fundamental evidence the school believes that addressing these issues is as important as reading, writing, and arithmetic. In addition, when included in the curriculum delivered by all teachers, rather than only by specialists, it increases students' opportunities for developing health-promoting behaviors. More indirectly, the manner in which the curriculum is provided and learning assessed contributes to a school environment that communicates high expectations for all students and a belief that all children can learn and are of value.

In many instances, the curriculum is realized and delivered outside the classroom setting. In nutrition education, for example, the school lunch room provides a tremendous opportunity to become the "learning laboratory." The responsibility for teaching sound nutritional practices and transferring that learning into daily practice requires a combined effort of teachers, parents and school food service providers.

"We hear more and more talk about health promotion and wellness, but the United States is still very much in a problem-prevention/treatment mode... We must recognize that ubiquitous substance-abuse-prevention curricula are not enough."
Karen Pittman
Michelle Cahill

"Clearly no knowledge is more crucial than knowledge about health. Without it, no other life goal can be successfully achieved."
National School Boards Association

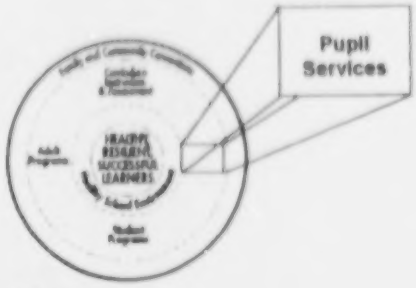
Jackson (1994) states that the emerging paradigm shift for comprehensive health education entails becoming student-needs driven, offering school and community-based services, and actually impacting youth behaviors rather than transmitting information and knowledge. Louis and Smith (1992) found that in nearly all cases when teachers were engaged with the school as a social unit, with students as unique individuals, with academic achievement, and with a subject discipline, they subordinated their own subject matter to providing a more interdisciplinary curriculum. These engagements clearly influenced school culture and youth development outcomes. The American Academy of Pediatrics, Committee on School Health (1993) reported on a study which indicated two key factors to a successful health education program are

the amount of time students are exposed to the curriculum and the extent to which exposure is accumulated from year to year (p. 103). A Harris poll (1988) found that students with three years of health education knew more about AIDS and were less inclined to use drugs or alcohol than students with little or no health instruction. In addition, they reported a greater feeling of control over their own health and following more positive health routines such as regular exercise and proper nutrition (Education Daily, p. 3). The ERIC Digest reports that children's nutrition habits are affected by the messages they receive from television and food packaging about foods high in sugar, salt, or fat. These messages can be countered by nutrition education in school, which is most effective when it is delivered in the context of a comprehensive health education program (June, 1994). Food service managers can be good resources for nutrition education and food service activities.

Developed by Gibbs and Bennett (1994), *Tribes* is an approach to instruction which focuses on the needs of students and involves the process of reflection. The authors use the metaphor of a tribe to convey the stages of community building that must occur in a successful classroom. "Inclusion" is the first stage in this process and it involves creating safe opportunities for students to present themselves, feel welcomed, and understand the structure the class will use. In the second stage, "influence," students are able to engage in activities, state their values and perspectives, and engage in consensus building. In the final stage, "affection," students as a group and as individuals are able to do their best, feel pride in accomplishments, and belong comfortably to the group. The reflective process described by Gibbs and Bennett includes reflection about content, interactions of the learning group, and individual learning and feeling.

Implementation of curriculum that deals with health and safety issues ought to be consistent with best practice as defined by education restructuring and reform. For this to become reality, teaching staff responsible for its delivery may require professional development on two levels. First, teachers who are often not prepared to teach about controversial issues such as human sexuality, violence, and alcohol and other drug abuse must become confident in their ability to do so through professional development opportunities. Time to sift through these issues, their connectedness and to define the desired outcomes or instruction is essential to move teachers to planning an integrated comprehensive curriculum target-specific to health and safety issues. Secondly, teachers of health and safety issues may require professional development to improve their ability to foster integration, critical thinking, self-reflection and student involvement during curriculum development and instruction. Developing classroom skills as a teacher-facilitator helps teachers implement the curriculum and assess learning from a student-centered approach. In addition to professional development, other implementation issues include developing community support and involvement; coordinating classroom instruction with student, adult and community programs; and developing classroom curriculum that reflects the school's mission and vision for the health of children.

The *Curriculum, Instruction & Assessment* component is closely connected to the other components of the Framework. As stated earlier, the *Healthy School Environment* is shaped, in part, by the instructional methods and degree of youth involvement in learning. *Student Programs* support classroom learning, enrich it and can give students a way to contribute to school programming by applying the skills they are learning. The range of content and methods used in *Curriculum, Instruction and Assessment* is decided through *Family and Community Connections*. Family and other community members may help plan, implement and evalutate instruction. *Pupil Services* support student learning. These staff members are resources to classroom teachers in the development, delivery and evaluation of the curriculum. Employee wellness and assistance programs in the *Adult Programs* component help adults to role model the desired outcomes of curriculum. Adult role models are a strong influence on student learning, often more so than direct instruction itself.



Pupil Services

Pupil Services are the four core disciplines of school psychology, school social work, school counseling, and school nursing which are organized as a collaborative team. This group follows a systematic procedure to provide leadership and coordination of the various student services programs and other system-wide activities which

impact student learning. Pupil services staff members are trained to support the healthy development of all children as well as those experiencing health and educational challenges. At some point in the school experience, every child will likely require the services of a guidance counselor, school nurse, school psychologist, or school social worker. Each pupil services provider has undergone training and preparation resulting in expertise in specific areas designed to help children succeed in school. The team of pupil services providers is an invaluable support to teachers, administrators, and families.

"Team building is seen as a way to sidestep the institutional resistance to change that lone reformers meet."
Gene Maeroff

Pupil services teams and delivery is explored in depth in *Pupil Services: A Resource and Planning Guide* (Mulhern, 1995). In addition, the Department of Public Instruction has four other resource and planning guides available which discuss each of the pupil services disciplines in detail.

Pupil services providers strive to support and encourage student success despite the multifaceted barriers that interfere with students' ability to succeed. Pupil services staff members advocate for children through the entire prevention continuum of primary prevention, intervention, and follow-up services. The delivery of *Pupil Services* is based upon mutual trust, respect, and collaborative teamwork among pupil services professionals, teachers, administrators, families, students, and the greater community. Members of the pupil services team vary in role, responsibilities, expertise, and interest, but all have in common the goal of *healthy, resilient, successful learners.*

Numerous models of pupil services delivery systems exist in school districts. While the Wisconsin DPI does not promote or endorse any single delivery model, it does recognize the need for conceptualizing the delivery of *Pupil Services* within the context of a common framework that is connected to the total school environment. An asset to the delivery of pupil services is strong leadership provided by an administrator such as a director of special education and pupil services.

The delivery of pupil services has changed over time. Schools have developed pupil services programs over the years to meet the needs of children experiencing problems such as depression, the abuse of alcohol or other drugs, child abuse, and educational failure. Also, they have developed pupil services programs to foster the healthy development of children.

Pupil services delivery in school districts is shaped by the district's mission and goals. Because *Pupil Services* are provided within the context of the educational environment and are tailored to complement the instructional program and learning environment, pupil services providers and administrators must align their work with the school district's mission statement and goals. Working toward accomplishing education goals, schools rely heavily upon the practitioners of the four pupil services disciplines. Various members of the instructional staff are closely involved in working with pupil services providers to help deliver services that meet the variety of student needs in order to accomplish educational success.

Maeroff (1993) discusses teams as an effective vehicle for school change and improvements in teaching and learning. In addition to school nurses, Kolbe, Collins, and Cortese (1995) identify school psychologists, school counselors, and school social workers as indispensable members of school health teams (p. 22). A report of the Committee on Children, Youth and Families of the American Psychological Association (1995) makes a strong case for the essential nature of *Pupil Services* for successful reformed schools. The report made an extensive review of available literature. These components were found to be present in successful early intervention programs: 1) early diagnostic evaluations to identify children at risk; 2) nutritional counseling or other services supporting children's physical health, and developmental counseling supporting children's emotional needs; and 3) parent education and involvement. Early intervention is critical to literacy in order to avoid the development of a pattern of school failure (pp. 10-19).

A position paper by the Wisconsin Federation of Pupil Services (1991) makes the case for delivery of *Pupil Services* in a team approach.

Clearly, pupil services are most effectively delivered through the team approach. The complex needs of students demand the comprehensiveness implied by uniting the skills of trained professionals. Through teamwork, school psychologists, school social workers, school counselors and school nurses, with other professionals, work together to provide coordinated services for students and their families. The pupil service team approach is based on the following concepts:

- *Pupil services programs should be developed from identified needs of students, parents, and administrators.*

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current involvement in unhealthy risk behaviors and to provide specific opportunities to develop skills to contribute to their school, their families, and their community.

Support for inclusion of *Student Programs* comes from the literature of both youth development and resiliency. One of the basic needs identified by Pittman, O'Brien and Kimball (1993) is building relationships with caring and connected adults. Likewise, caring and support is one of the protective assets within the school environment identified by Bonnie Benard (1991). This need or asset is one of the fundamental elements of *Student Programs* as listed above. Pittman, O'Brien and Kimball (1993) also identify the basic need of engaging in meaningful activities. Benard (1991) refers to this as opportunities for participation. *Student Programs* provide these meaningful activities and opportunities for participation. In the same article, Benard cites two meta-analyses (Tobler, 1986; Bangert-Downs, 1988) which concluded peer programs, including cooperative learning strategies, are the single most effective school-based approach for reducing alcohol and other drug use in youth. In an update of her meta-analysis, Tobler (1993) found more interactive prevention programs were more successful. Student programs in Wisconsin which were originally designed to focus on alcohol and other drug issues have been expanded significantly to address other youth risk behaviors as well (Wisconsin DPI, 1995).

"A factor often overlooked is the role of caring peers and friends in the school and community environments."

Bonnie Benard

There are many examples of *Student Programs* discussed below. *Alcohol and Other Drug Abuse Programs and People: A Profile of Resources in Wisconsin School Districts* (Wisconsin DPI, 1995) provides lists of specific types of student programs in the vast majority of the state's school districts. Included are the names and telephone numbers of the districts' coordinators. It was designed to be used as a resource for districts to contact each other directly about their respective activities.

Extracurricular Activities

Clubs and other extracurricular activities give students an opportunity to belong to a group which is organized around a common activity or theme. This theme may or may not address a specific or broad health issue. For instance, SADD chapters were originally organized around an anti-drinking and driving theme. Over the last few years, the national SADD office has promoted other themes, such as Students Against Dangerous Decisions and Student Athletes Detest Drugs. Clubs give students a chance to plan and carry out activities of their choice. Community service projects may be activities of these groups. Student government allows students to have input into decisions which affect their school through a representative, democratic format. Student courts are designed to allow peers to decide consequences for students who violate a predetermined list of infractions, much like a municipal court system. Intramural sports such as soccer and basketball and clubs such as bowling and skiing promote physical and emotional well-being and an active lifestyle. Sports and clubs with physical activity encourage family involvement and feelings of community at school.

Peer Programs

Peer programs fall into four general categories: peer helpers, peer educators, peer leaders, and peer mediators. Peers are usually the first to hear of suicidal tendencies, physical or sexual abuse, teen pregnancies, and alcohol or other drug-related problems. Moreover, crises often occur outside of regular school hours when adult professional helpers are not easily accessible. Peer helpers are trained to listen and help students obtain the help and support they need within the school or greater community settings.

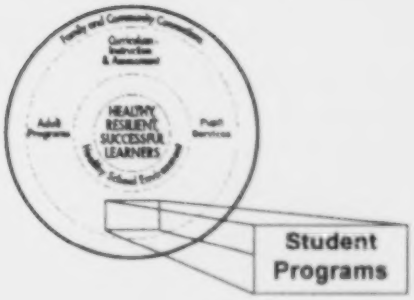
Peer educators specialize in going into the classroom to teach students about health and wellness issues, communication and coping skills, and other related personal development topics. They serve as role models, communicate the belief that unhealthy risk behaviors are unacceptable and give suggestions for alternatives to those behaviors, show that they value good health and wellness, teach peer refusal skills by citing real-life situations, supply information on "what it's really like," and provide experiential education aimed at changing behavior.

A peer leadership program involves selecting students who are natural leaders and then training them in basic leadership and peer program skills with an emphasis on group cohesiveness and team building. Participants look at problems in their school and community (e.g., gang activity) and then develop and implement plans of action for improvement. The basic principle operating here is the peer influence of student leaders promoting positive activities. Students feel pride and ownership

- *All pupil services are related and must be coordinated for optimum effectiveness.*
- *Pupil services demand developmental, preventive, and remedial emphases, thus requiring the contributions of all pupil service disciplines.*
- *Pupil services facilitate effective linkages between the school community and external community resources.*
- *Program evaluation is critical to pupil services teamwork.*
- *The teamwork required for achievement of pupil service objectives requires trust, open communication, mutual respect, ongoing collaboration, and effective coordination.*

There are many examples of *Pupil Services*. Pupil service providers conduct individual assessments as part of multidisciplinary team evaluations. Other teams they may serve on include building consultation and crisis intervention teams. Pupil services staff often direct and facilitate groups in student assistance programs as well as providing individual counseling to students. Parents also benefit from *Pupil Services* through support and education groups; home visits; referrals to community-based organizations; and individual consultation concerning their children's health, behavior, and academic progress. Pupil service providers provide classroom instruction in areas such as developmental guidance; protective behaviors; alcohol, tobacco, and other drugs; nutrition; human growth and development; HIV and other sexually transmitted diseases; and conflict mediation. Peer programs are often managed by pupil services staff members who may also be qualified to train students in the roles of peer helpers, educators, leaders, or mediators. These staff are frequently called on to provide professional development activities to fellow school staff. They are often at the forefront in the development and management of family-community-school partnerships involving human services, health departments, law enforcement, and area employers. Program evaluation is another area of expertise for pupil services staff. Employee assistance and wellness programs may be organized through pupil services departments in school districts.

Clearly, from the examples listed above it is apparent that *Pupil Services* are integrally involved in the service provision in all of the other components of the Framework through leadership, coordination, instruction, training, and assistance. Without their services, some students would not have the necessary support to become *healthy, resilient, successful learners*.



Student Programs

Student Programs are selected by or provided to students based upon specific student needs or preferences related to their health and development. There are a number of elements to this component of the Framework.

- Participation is voluntary and open to all students with specific preferences or needs. Students apply and develop knowledge and skills which transcend personal gain or benefit through leadership, contribution to the school-community environment, and support of fellow students.
- A strong focus is on developing life skills, mutual support and assistance, and alternatives to unhealthy risk behaviors.
- Activities and services stress relationships with other students and adult role models, in pairs, small groups, and large groups. Adults help facilitate these interactions.

Student Programs can help address students' physical, emotional, social and cognitive needs which are foundations for life-long health, learning and success. They help students connect to the school and the greater community. Students experience the value of working to achieve goals beyond personal, self-centered needs. They are perceived as a resource and role model to other students. Adults are able to interact with students in a less structured, less directive manner. Early intervention with students in such group settings can

Youth are not the problem but must be part of the solution.
Guiding Principle #2

be done much more efficiently than individual services.

Student Programs give schools the capacity to go beyond primary prevention and fulfill the continuum to include secondary (i.e., early intervention) and tertiary (i.e., recovery support) prevention services. They give schools the capacity to address the unique life circumstances of students, both to prevent

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in their school, the school climate improves, and social bonding becomes stronger.

Like peer helpers, peer mediators are trained to listen. They work with two or more students who are in conflict and attempt to help them follow a specific process to come to an agreement to resolve the disagreement.

Student Assistance Programs

Student assistance programs have the function of providing support and education, typically through small groups, to students who are experiencing personal difficulties which may adversely impact their school performance. Groups are organized around specific topics, such as Concerned Persons, Awareness, AODA Use/Abuse, Recovery Support, Friendships, Grief and Loss, Teen Pregnancy, Self Esteem, Divorce, and Weight Loss/Gain. Individual counseling may also be offered.

> ***"Without question, literature from many disciplines support youth involvement. Youth engagement will happen only when adults begin with a vision of positive youth development and make necessary systemic changes. These changes will create environments in which young people can tap their own innate potential for full intellectual, social, and personal development. The new environment will include programs, activities, and opportunities which grow out of this vision."***
>
> Midwest Regional Center for Drug-Free Schools and Communities

The team approach to student assistance programs relies on the identification and training of key school staff at the building level, each of whom, by virtue of his or her role in the school, performs a vital function in managing students experiencing one or more youth risk behaviors or related problems. Wisconsin statute 118.126 provides specific confidentiality rights to students participating in student assistance programs for AODA-related problems. Students may refer themselves to the student assistance program or be referred by school staff, friends, family members, or someone from the greater community. Participation is voluntary. Many counties in Wisconsin have formal arrangements between the court system and schools which operate student assistance programs. Judges may offer a reduced or suspended fine or other consequences to students who successfully complete AODA Use/Abuse groups. Some schools offer reduced sanctions to students who violate the student athletic or extracurricular codes if they voluntarily access the student assistance program.

Mentors

Mentors are adults paired with students to serve as role models and provide general guidance to the young person. Mentors may come from the school or community. Older students may also serve "big brothers or sisters" in role model relationships. Foster grandparent programs typically have a primary function of tutoring, but it is not uncommon for these pairs of older adults and students to voluntarily get together for other activities unrelated to school (e.g., go to a movie).

Student Programs complement the *Curriculum, Instruction, and Assessment* component. The connections between what is taught in the classroom and what is practiced or applied in *Student Programs* should be clear to both students and staff. These programs can be used to identify important problems in the *Healthy School Environment*, providing channels of student input and feedback. These problems may be addressed in part by facilitating students to focus peer group efforts on problem-solving through special projects and activities. Student minigrants available annually through DPI can help to fund these efforts. Many *Student Programs* build upon or create links betweeen the school and the greater community. These links are examples of *Family and Community Connections*. Student community service learning projects related to health and safety issues help both students and the community. Community contributions of volunteers, money, facilities and incentives are essential for many *Student Programs*. Many *Student Programs* rely upon family volunteers to help plan and run clubs and events. Referrals to community services form an important part of Student Assistance Programs. *Student Programs* may serve as an avenue to assess needs and change community

> ***Learning from research and practice is crucial.***
>
> Guiding Principle #6

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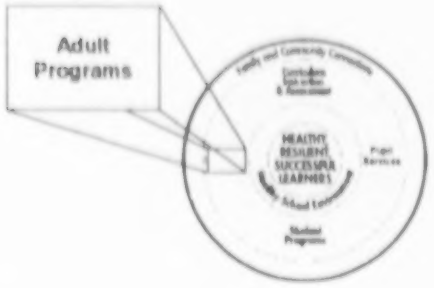
conditions for students and families. *Student Programs* may be coordinated through a school-community advisory council which includes family members. *Pupil Services* staff are often highly skilled in the type of facilitation skills needed to guide student program efforts, particularly small groups. They can provide an important resource both in training students and in training other school staff and community volunteers to facilitate student groups and activities. Because of the demands on teachers' and administrators' time, operation of some *Student Programs* may be very limited without significant involvement of pupil services providers.



Adult Programs

Adult Programs provide information and support to adults directly involved in the care and education of students. There are three primary elements involved: professional development for staff and interested community members, parent education and support programs, and employee assistance and wellness programs. The true challenge for schools when developing their *Adult Programs* lies in identifying the needs and means to motivate all adults to get involved in meaningful health promotion.

Professional Development

Professional development is necessary for program improvement, reform and restructuring of education, and integration of services. People can be empowered to take on more responsibility and decision-making roles and can gain the necessary skills to relate to an increasingly diverse student body. They may develop an increased understanding and support for the belief that prevention, health, and youth development are part of the basic mission of the school. Fine (1994) challenges traditional assumptions about professional development. For instance, occasional inservices are not adequate and listening to an expert is not optimally effective. Sparks (1994) details three forces shaping the new direction for professional development: impact on students, systems thinking, and constructivism. These major changes are noted. There must be a shift from individual development to individual and

"There are only two lasting bequests we can hope to give our children. One of those is roots, the other is wings."
Hodding Carter

organizational development. Fragmented, piecemeal staff development should be replaced by a clear, coherent strategic plan for districts, schools, and departments. School building staff should plan and conduct professional development with district assistance and support. Training away from the job should be replaced by job-embedded learning. Consultation and facilitation should be more important than training. Staff developers should assist teachers and administrators in assuming their new role as educators or adults. There should be movement away from teachers as recipients to continuous performance improvement by all adults.

Parent Programs

There are only two lasting bequests we can hope to give our children, Hodding Carter once said. *One of these is roots, the other is wings.* Many of us have been fortunate to grow up in families which gave us "roots" of strong values and "wings" of self-confidence. Our parents were our primary prevention agents and supported the efforts of our teachers and schools to educate us. But parenting has changed a great deal in the last two generations. Mobile families make it much more difficult to develop neighborhood support networks. Two-income families have resulted in more children spending unsupervised time at home. Children, at ever-younger ages, are exposed to mass media marketing of alcohol use, sexual activity, and violence. And, single parents, denied another adult within the home on whom to rely for help, are faced with an even tougher task of parenting. A 1993 survey of Wisconsin parents found that of the 65% that said they preferred schools teach abstinence from alcohol as appropriate behavior until age 21, over half said they would occasionally allow their child to drink if they were present or on special occasions or holidays (DPI).

Parent education is one of the most direct methods to help equip parents with the knowledge

and skills to parent effectively. It can be as minimal as an article in the school newsletter or a speaker at a workshop, or as extensive as a series of structured classes. Parent support emphasizes a cooperative approach which may be more successful for parents who lack the skills or confidence to apply the information typically provided through parent education. Indeed, education alone, for parents with limited confidence in their child-rearing abilities, may actually reinforce their perceptions of themselves as inadequate parents because they see themselves as unable to put to use the information they have been presented with. Examples of parent support include support groups and informal neighborhood networks which let parents express their feelings in a safe atmosphere. They are able to share similar feelings and experiences with others. They profit from knowing that they are not alone in struggling with normal parenting challenges (DPI, 1993). State discretionary Families and Schools Together grants are available through DPI for schools to develop programs which target families with high-risk elementary age children. These programs are operated with AODA and mental health specialists and generally emphasize parent support and education.

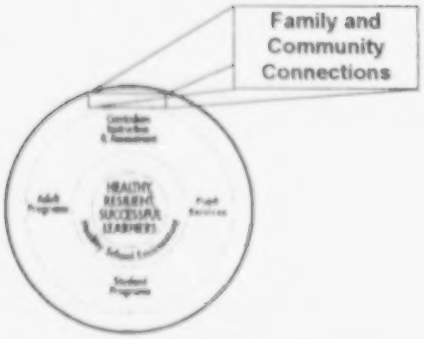
Employee Assistance and Wellness Programs

Employee assistance and wellness programs support adults so they can support children. Productivity can be increased, staff attrition and absenteeism can be reduced, as well as health care costs. Healthy adults who manage the stress in their lives well can interact more positively with a diverse student population and model the behaviors we hope youth will adopt as their own.

Employee assistance programs were originally developed following World War II and spread throughout the private business sector because it was found it was more cost effective to help and retain employees experiencing personal difficulties as opposed to terminating their employment and then hiring and training new employees. Since an employees' personal issues can affect not only their job performance but that of other employees, addressing these issues makes perfect sense. Assistance comes in many forms and with various degrees of urgency. Sometimes it means information: where to get day care for a child, homemaker help for an ailing parent, or assistance with problems in such areas as legal and financial matters, marital and parent-child relationships, and the use of alcohol and other drugs. At other times assistance means specific referrals to service agencies in the community as a result of, for example, an impending divorce or a serious drinking problem within the family (DPI, 1991, p. 56). Employee assistance programs may utilize internal resource coordinators or may be contracted to outside organizations. Resource coordinators should be drawn from all parts of the school system and receive adequate initial and annual training. Any involved outside agencies must be easily accessible and non-threatening to employees.

Employee wellness programs have a goal of improving staff morale, productivity, and school climate in each building by fostering wellness. These programs are for all staff members at all levels. Health promotion programs for staff members are the best predictor for successful health education programs in schools. The next best predictor is the health-related behavior of the building principal (DPI, 1991, p. 58). Wellness includes the dimensions of exercise, nutrition, stress reduction, and health/safety awareness. A wellness program involves an organized effort to promote good health and self-care among staff. We want students to take care of themselves. One of the best ways to do this is through modeling self-care by school staff. Both groups benefit. The concerns for wellness are cross-generational. They are shared by all people throughout their lifespans (DPI, 1991, p. 58-59).

Many *Adult Programs* build upon or create links between the school and the greater community. These links are examples of *Family and Community Connections*. All elements of *Adult Programs* can be coordinated through a school-community advisory council which includes family members. Employee assistance and wellness programs may serve families of school staff and may be part of larger programs serving a variety of community worksites. They are important to developing and maintaining a *Healthy School Environment*. The school district is then modeling the same care and support for its staff that it wants its staff to provide for students. Community organizations and agencies may provide staff, volunteers, information, facilities, and other resources to all kinds of *Adult Programs*. Professional development opportunities offered through *Adult Programs* help provide necessary knowledge and skills needed for staff to work more effectively in the *Curriculum, Instruction, and Assessment*, *Student Programs*, and *Pupil Services* components.



Family and Community Connections

Family and Community Connections consist of the various formal and informal working relationships between schools, the greater community, and the families that live and work within them. These relationships involve networking, cooperation, coordination, and collaboration on health, prevention and youth development issues. A key ingredient to successful *Family and Community Connections* is an understanding that working together is a two-way street. All parties should have a common understanding of shared responsibilities and goals.

The *Family and Community Connections* component of the Framework is very different than the previous four. It consists of relationships rather than programs and services. These relationships provide the essential community context and support system for the school-community's efforts to promote *healthy, successful, resilient learners*. The other components depend on the relationships that comprise *Family and Community Connections* for support, resources and the shared vision that provides direction.

As related earlier, Benard (1993) characterizes a resilient community as *a motivated community where people solve problems together* (p. 1). The African proverb, *It takes a whole village to raise a child*, is a common statement heard today in school-community efforts, such as Village Partnerships. A Midwest Regional Center literature review (1995) reminds us that each young person's environment has at least three important facets at all times: family, school, and the greater community. They are not separate and distinct and what happens to children in one environment affects them in the other two (p. 11-12).

If school-based systems, such as those described in the Framework, are to be effective and lasting, their planning and evaluation must be community-based. The school, after all, is a part of the community, often serving as a focal point. Extensive community-wide involvement in and support for all phases of change is essential if the improvements are to begin, evolve and succeed. A broad spectrum of people representing the diversity of the community and several key community systems need to lead the creation of these changes towards a more integrated, comprehensive system. These people will likely include, but are not limited to, parents and other family members, students, public health staff and other health care staff, human services staff, school administrators, teachers, pupil services staff, other school staff, staff and faculty from higher education, religious leaders, business leaders, civic and neighborhood leaders, and law enforcement officials.

As a result of this community involvement, broad support for school-based systems to promote *healthy, resilient and successful learners* is possible. Without it, it is not. Extensive outreach, education, and two way communication is needed to assure that school-based systems reflect (and help shape) community norms and values on *healthy, resilient, successful students*. This process may begin by establishing a common vision for what the community wants for its students in terms of health and development. The school board, as the elected community representatives, needs to understand, sanction, and financially support the change process.

Collaboration

Through this community-wide involvement and a common vision, it is possible to develop collaboration between school-based systems and efforts based in other segments of the community. This can include collaborative service integration, whereby resources from the school and other parts of the community are combined to provide more comprehensive, accessible and appropriate services than any agency or organization alone could provide.

Despite its attention in the literature, collaboration is not the answer to all problems. It is not a goal but a means to an end. Collaboration is a complex, time-consuming process which should be utilized selectively in association with appropriate circumstances. The terms networking, cooperation, coordination, and collaboration are used frequently and sometimes interchangeably. In truth, they are very different.

The Pacific Institute for Research and Evaluation (PIRE) developed a process-oriented assessment instrument with DPI to help school districts integrate their services, programs, and instruction which deal with health, youth development, and the prevention of risk behaviors. PIRE references Arthur Himmelman's typology of community organization

and modifies his definitions of networking, cooperation, coordination, and collaboration.

1. Networking - Exchanging information for mutual benefit. Often is informal. Demonstrates that an initial level of trust and communication has been established. Usually works best when the link is person-to-person, with designated contact persons through whom a continuing dialogue can be maintained.
2. Cooperation - Exchanging information **and** sharing resources for mutual benefit and to achieve a common goal. Requires more organizational involvement than networking. Requires dealing with relationships and turf issues. Demands frequent communication, a sound level of trust, and problem-solving. Resources is broadly defined, encompassing a variety of human, financial and technological contributions including knowledge, staffing, physical property, access to people and money. Those capable of bringing financial resources to the table do not enjoy greater power than those bringing other types of resources.
3. Coordination - Exchanging information, sharing resources, **and** altering activities for mutual benefit and to achieve a common goal. Altering activities means changing program schedules and/or content to better serve the client. If duplication of service is discovered, altering activities may mean elimination or a different delivery system for certain activities. Requires elimination of turf issues and a high degree of trust and communication.
4. Collaboration - Exchanging information, sharing resources, altering activities **and** enhancing the capacity of a partner for mutual benefit and to achieve a common goal. This step involves risk-taking and true sharing of responsibilities, resources and rewards. Partners have evolved to truly wanting all members of the collaborative to become better at serving the client. This step involves a high level of maturity; self-interest and self-enhancement have become non-issues.

In truth, these definitions apply not only to schools working with the greater community but also to schools working within themselves. School staff must work at networking, cooperating, coordinating, and collaborating with each other as well as with community members and organizations if a system of integrated, comprehensive programs, services, and instruction is to be developed.

The National Association of Secondary School Principals (1992) offers a list of key elements to schools and community organizations working together:

1. *Goals. Be clear about why you are working with acommunity agency. Be specific about what problems, concerns, or issues are to be addressed. Define the target population.*
2. *Roles. Define roles for both the school and the agency...*
3. *Balance. Collaboration implies everyone contributes something... A second element of balance is efficient use of existing resources...*
4. *Equality. Respect each other and work toward the best interests of the student, family, community, and school...*
5. *Trust. Be candid about the risks and mutual benefits of working together...*
6. *Coordination. To ensure plans progress as designed and goals are accomplished, a system must be established to coordinate collaborative efforts... Signed formal letters of agreement that detail who does what, when, and how are common...* (p. 1).

The Midwest Regional Center has distributed an article by Charles Bruner (1991) entitled *Thinking Collaboratively: Ten Questions and Answers to Help Policymakers Improve Children's Services.* The Department of Public Instruction held a single day gathering in 1993 of people from throughout the state experienced in family-community-school partnerships. The result was a publication later that year entitled *Benefits and Obstacles to Collaboration.*

Collaboration and teams are important to a comprehensive continuum of services, because meeting the needs of children requires the combined capacity of all segments of society.
Guiding Principle #7

Community Connections

In the majority of Wisconsin's school districts, the school is the focal point of the community. Oftentimes, the school district is the community's largest employer. Without community support for school programs and activities, success is difficult, if not impossible to achieve. Messages youth receive from the community can inhibit or enhance the school's efforts in prevention and youth development. For example, if *healthy, resilient, successful learners* are a school goal and the community has no related programs, achieving the goal is difficult. Students may also receive the message that the school's goal is unimportant if there

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is no community support. If the school has wellness and prevention curriculum and programs, then the message from the community about wellness and prevention of youth risk behaviors must be consistent with that of the school.

Connecting the school and greater community systems is a way to more efficiently and effectively provide services that both have as a priority. Schools are typically centers for neighborhoods and sometimes entire communities. Indeed, much of a community's identity is often derived from its schools, as evidenced by the amount of pride taken in athletic and other extracurricular activities. Schools that are essentially vacant and not used for school and greater community activities during evenings, weekends and summers are underutilized.

Recreational facilities such as swimming pools, fieldhouses, and ball parks are used by students in schools and community members alike. Initial funding and ongoing operational costs can legitimately be a joint venture of the school district and the municipality.

There are many other examples of community connections. State law requires children attending school be immunized. Having the local health department offer free immunizations at the school keeps children in school, helps parents comply with the law, and reinforces the message from the school and greater community that the health of children is important. School staff can serve on county adolesent health councils and other planning and advocacy groups, while community health care professionals can help plan school health services. Use of police-school liaison officers can enhance the safety of the school-community environment and help children to see police officers as supportive and approachable. Effective instruction necessitates extension beyond the school-based classroom, both in terms of students' thinking and their actual presence. School-to-work transitions and service learning cannot be successful without strong connections to the community's employers.

Parent Involvement

Parent involvement in their children's educations, from birth until they leave home, has a major positive impact on children's achievement at school. These benefits include higher test scores, better grades, more consistent attendance at school, more positive attitudes and behavior, and more effective academic programs (Macfarlane, 1995). Parent involvement with the school models congruent behavior for children in their two most important environments. Greenburg (1989) notes that children's school success is dependent on both parental endorsement of the school and the amount of respect given to the parent by school staff. The amount of work done by parents for their children's schools is not a critical variable (p. 62). Mills (1994) found that an empowerment approach to parents brought impressive results even in the most adverse circumstances. The Chief State School

Families are the best primary prevention and youth development agents for their children.
Guiding Principle #5

Officers Council (1989) offers this advice:

Given the broad needs and the repercussions of inaction, it is a legitimate responsibility of the education system to provide greater assistance, coordination of services and support to families so that they have a stronger capacity to assist in the education of their children. It is also the responsibility of the education system to accept families as full partners in the education of their children and develop this relationship in the design and implementation of programs affecting children (p. 4).

Likewise, Edwards and Young (1992) suggest *creating a process for parents to become integral and confident partners in their children's schooling* (p. 76). The Midwest Regional Center (1995) states:

Perhaps the most important finding in the literature about parental involvement is concrete evidence that a positive approach can, indeed, ignite parents' innate potential for full and healthy development. Such an effort to strengthen parents is a critical part of successful youth development.

A range of parent involvement strategies can offer parents and other caregivers opportunities to be service providers and advocates as well as consumers. Examples include parent networks, participation in advisory councils and planning groups, parent-teacher organizations, and instructional and program support. Properly trained, parents are able to serve as classroom instructors and student group leaders as long as they receive the necessary support of professional educators.

The Families in Education Program at DPI provides a framework for participation and resources for development of family-community-school partnerships (1993a). A checklist is included which helps schools to assess their status concerning family-community-school partnerships. This model is based upon the research of Joyce Epstein (1992). It notes six types of family-community participation which are all grounded in a student-centered

learning environment: parenting, communicating, learning at home, volunteering, governance and advocacy, and community outreach. Families in Education resource packets, previously shared with all Wisconsin school districts and CESAs, provide a wealth of suggestions for educators.

School-Community Advisory Council

Within the context of this Framework, a school-community advisory council is the body of individuals that coordinates the services, programs, and strategies developed to address youth risk behaviors and promote health and youth development. The group gives structure and a forum to all of the relationships within the school-community environment and between the school and the greater community. Additionally, the council may have responsibility for the evaluation of all components within the Framework. Membership of the council includes people from the groups listed before on page 18.

Allensworth (1987) recommends the formation of local advisory committees to promote comprehensive school health programming. The school-community advisory council can exist at both district and building levels. Many districts have seen the wisdom of consolidating advisory councils which previously dealt separately with issues of alcohol and other drug abuse, human growth and development, and children at risk. Members of the council need to understand and accept their role as strictly advisory to the school board and administration. The Midwest Regional Center (1995) cautions there is no recipe for the universal structure, committee, council, program, or organization that will fit every need.

Family and Community Connections are the bridge between structure (i.e. the six components) and process in the Framework. Strengthening these connections is a key aspect of a systems development process to improve *Curriculum, Instruction, and Assessment, Pupil Services, Adult Programs* and *Student Programs*. The school needs to work in concert with the greater community of which it is part. The relationships that make up *Family and Community Connections* provide support and direction to all other components of the system. *Family and Community Connections* help establish student health and well-being as an essential part of school business, thus forming the basis for a *Healthy School Environment*. Through relationships with families and the broader community, schools determine which health and safety issues will be addressed through *Curriculum, Instruction and Assessment* and *Student Programs*. Family and community resources help support *Adult Programs, Students Programs,* and *Pupil Services*. *Adult Programs* provide services for families based on their strengths and needs. The school-based system supporting *Healthy, Resilient, Successful, Learners* can only be effective with diverse, strong *Family and Community Connections*.

Conclusion

Relationships within and among (people working in) the various Framework components provide direction and energy that builds a system's capacity to promote health and youth development and reduce risky behavior. These relationships are key to developing effective systems. The Framework serves as an example of how school-communities can organize their programs, services, and instruction into an integrated, comprehensive system which promotes health and youth development and reduces involvement in risk behaviors.

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The Student Services/Prevention and Wellness team employs an integrated services approach to its work. The team provides inservices, staff development and technical assistance in the development and implementation of programs and services that help students in their social, personal, health, educational, and career development. Included are counseling and guidance, nurse, psychological and social work services; alcohol and other drug abuse; alcohol and traffic safety; school age parents; AIDS/HIV/STDs; suicide; child abuse and neglect; human growth and development; children at risk; and school violence. A variety of prevention education and health promotion programs are administered by this team and comprehensive school health program initiatives are promoted.

Cooperative Educational Service Agencies

Cooperative Educational Service Agencies (CESAs) provide staff development, materials, networking opportunities, and other services and resources to school districts and other organizations in many areas, including health and safety issues. CESAs are an excellent service delivery vehicle for assisting schools in developing and implementing CSHP. In addition, schools seeking to make stronger connections with human services, public health, youth organizations, law enforcement and juvenile courts, and other groups in the greater community may find help through a statewide network of county and regional school-community partnership councils supported and sponsored by CESAs. Most, if not all, of these groups are locally represented on these councils. Below are contact people within each CESA for CSHP.

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